Women's Center for Health

Annual Physical Exam Acknowledgement Form

Pt Name: _____ DOB: _____

I _____ am here for my annual physical examination and acknowledge that the services performed, related to this visit may not be covered by my insurance company. I understand that the physical exam, and any additional testing necessary, including but not limited to; blood work, pap smear*, HPV** will become my financial responsibility if my insurance carrier does not provide full reimbursement (for any reason). Furthermore I understand that once the services are submitted to my insurance carrier Women's Center for Health will not change the diagnosis and/or procedure codes billed.

*Please note that in the event of pap test results coming back with insufficient cells, you will need to come back to the office for a repeat test. There will be additional charges that may not be covered by your insurance carrier, which will become your financial responsibility.

**Please note if HPV test is performed as recommended by your provider it may require further testing based on the initial results. Further testing is automatically performed by the lab and does not require additional consent. Extra charges will occur that may not be covered by your insurance carrier, which will become your financial responsibility.

By signing this form I acknowledge and agree with specifications listed above and assume full financial responsibility for services performed and not covered by my insurance associated with my annual physical exam.

Patient Signature:_____ Date: _____